A Model of Consumer-Provider Partnership: Vet-to-Vet

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Abstract

Recently, there has been increased interest in consumer-provided mental health services. Two models have been proposed; one emphasizing full independence from professional services, and one in which consumers work within the mental health system. In this paper we describe Vet-to-Vet, a consumer-professional partnership model in which consumer services are embedded in a mental health system. We describe the advantages of this approach, and barriers to implementation of other models. Vet-to-Vet has several unique elements, developed and implemented by consumers with professional consultation and supervision. We believe that consumer-partnership models of consumer-provided mental health services have potential for minimizing implementation barriers and for maximizing long-term sustainability.

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The last decade has seen increased interest in consumer-provided mental health services (Carlson, Rapp, & McDiarmid, 2001). The social support and access to role models offered through these services are thought to foster hope and promote meaningful community involvement. Anecdotal evidence and some empirical studies provide preliminary support for the effectiveness of consumer-provided services (Chinman, Rosenheck, Lam, & Davidson, 2000, Davidson, 1999, Solomon, 2001).

Two models of consumer service provision are most prominent: consumer-run agencies operating independently from professional mental health centers, and consumers hired as providers within mental health centers. Barriers to both models exist. Independent consumer-run agencies may not appeal to consumers who prefer to receive their mental health care from professionals or in professional environments. Additionally, this model requires that consumers travel to a separate location for these services, adding transportation barriers that may impede attendance. Without steady referrals from professionals and easy access for consumers, both of which are currently in short supply (Davidson et al., 1999), independent consumer-operated agencies may not be self-sustaining (Burns-Lynch & Salzer, 2001).

Although the strongest empirical evidence supports the effectiveness of consumers as employees (Chinman et al., 2000, Davidson, 1999), barriers may impede implementation of this model. First, integration of consumer-providers in mental health agencies that do not have such services is likely to be a lengthy process, requiring substantial system and culture change. More immediately, there is the potential problem of dual relationships with colleagues who may have been formerly (or currently) service providers of the consumer employees. This model also runs the risk that the professionals will either intentionally or unintentionally influence consumer providers to adopt ³professional² beliefs and roles, thereby diminishing their unique perspective as consumers. Over the last two years, consumers and providers at VA Connecticut Healthcare System have developed a consumer-professional partnership model of consumer-provided services called Vet-to-Vet. VA mental health staff have partnered with veteran-consumers in all phases of conceptualization and implementation of Vet-to-Vet, which is designed to provide easy accessibility to services for veterans and to allow consumer providers to receive supervision and consultation from professional staff, while still remaining separate from and independent of professional services. We believe consumer-provider partnerships have the potential to reach large audiences, and blend the most successful elements of the consumer-provider models described above.

Vet-to-Vet Meetings

Vet-to-Vet is an adjunct to existing services and is entirely voluntary. Although primarily attended by veterans who are currently receiving services from the psychosocial rehabilitation program, meetings are open to all. Each 45-minute

meeting is held at the same time each day when there are no competing staff-led activities. Specific topics are designated for each of the five weekdays: Disability Awareness, Disability Pride; Recovery Workshop; Writers[1] Meeting; Wellness; and Mental Illness Anonymous (MIA). Meetings are educational in orientation, and structured around reading material. However, there is flexibility in what is selected and discussed; if there are pressing issues, reading material addressing that topic may be substituted for the planned text in order to facilitate discussion on relevant issues. Confidentiality is discussed at the beginning of each meeting. Peer facilitators are not staff and do not document in patient charts. However, facilitators maintain confidentiality, except when obligated to notify staff due to suicidality, homicidality, and threats of violence.

Peer Nomination

A structured recruitment process was developed for periods of peer facilitator turnover. However, potentially conflicting goals of the selection process made this challenging: facilitators should be selected by their peers with minimal staff involvement; however, peer facilitators and staff agreed that there should be formal qualifications for becoming a peer facilitator. It was also decided that it was best for staff, rather than peer facilitators, to approach [3]new recruits[2] to determine their potential interest in becoming a peer facilitator. The solution, developed by the peer facilitators, is the nomination procedure described below:
Current peer facilitators may nominate individuals based on the following qualifications: evidence of commitment, sincerity, responsibility, and consistency; attendance and completion of a three-month group-based treatment program; and previous attendance at Vet-to-Vet groups. Nominations are discussed during group supervision, and new trainees must be approved by a unanimous vote. Staff then approach the nominated veterans and invite them to join the next training session.

Training and Supervision

Training consists of four weekly 45-minute training classes and ongoing observation and feedback, and is held whenever new nominees agree to become peer facilitators. In addition, trainees are expected to co-facilitate 2 groups a week during the training period. Classes are designed to provide a conceptual framework to complement the [3]on the job training[2] of co-facilitating groups. Trainees are monitored with The Peer Facilitator Rating Scale (PFRS, available from the first author) developed for the purposes of supervision and monitoring of fidelity to the Vet-to-Vet model. The PFRS was based on two existing instruments, the Skills Training Implementation Scale (Bond, Evans, & Resnick, 1998) and the Work Performance Inventory (Bryson, Bell, Lysaker, & Zito, 1997). Peer facilitators in training are observed and rated on the PFRS by a current peer facilitator. After the meeting, the trainee completes his or her own self-ratings on a second copy of the PFRS. Then, the trainee and the peer facilitator compare and discuss their ratings, which allows for concrete feedback and supervision. Ratings are made in the following areas: Preparation (e.g., peer facilitator is on time), Orientation (e.g., presents overview of day[1]s topic), Facilitation skills (e.g., encourages everyone to participate), Meeting Protocol Adherence (e.g., circulates attendance sheet), and

General (e.g., is appropriately dressed). Mandatory weekly supervision groups are co-led by a professional and a peer supervisor. Supervision topics vary, including discussions of how difficult situations were handled during the prior week, self-care, the status of the Vet-to-Vet program, and peer facilitator recruitment.

Lessons Learned

In designing the Vet-to-Vet program, staff and veteran-consumers have explored new ideas through trial and error. At first, peer facilitators did not have the experience or the skill to take primary responsibility for the program. Staff took a larger role in the day-to-day running of the program than they had originally planned and were concerned about usurping the sense of consumer ownership. However, once it was decided that staff would take a larger leadership role in the early development of the program, veteran providers became more relaxed, and with time, gained confidence and skill, and reshaped the program to better fit their vision. For example, while two staff used a staff-designed curriculum to train the first ³class² of peer facilitators, a peer facilitator and a staff member, using a curriculum completely designed by the peer facilitators, trained the next cohort. Thus, over time, consumers and professionals have together redefined and clarified their roles in a developmental process (Kaufmann, Freund, & Wilson, 1989).

Another aspect of the Vet-to-Vet program that we believe has been crucial to its development is that peer facilitators are paid by a separate entity, in our case, a nonprofit agency that operates under contract with the VA. Peer facilitators are thus not VA employees. This helps to reinforce to other veterans that peer facilitators are not staff, but are veterans with similar experiences and histories. Further, only designated professionals program directors and other professionals in leadership roles at the VA serve as consultants. This minimizes the potential for dual roles, and helps to maintain the consultant/partnership model.

Conclusions

Despite the promise of consumer-provided services, there have been few models delineated in the literature. Further, there has been little research evaluating peer-based psychoeducation, either in terms of traditional outcomes such as symptoms and rates of hospitalization, or in terms of the broader domains of recovery. Vet-to-Vet is a new model of consumer provider partnership, which can be integrated into existing mental health services, thereby increasing its long-term viability. A formal program evaluation of Vet-to-Vet, while still ongoing, has potential to add to this existing literature.

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